WMC Retrospective Research Findings and Early Insights

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Dr. Blasey:

We asked for the prevalence rates for substance-abuse related cases in our managed mental health care system. This data is broken down by treatment episodes. So we did some preliminary checking and we found that there were approximately 16,000 treatment episodes for employees, or 40,000 if you included covered lives.

We looked at diagnosis as well, but we had codes, and hopefully we're going to be able to change those into ICD-9 codes. We also ran some preliminary cost data. It's interesting when you ask for cost data, because it can come in a lot of different formats. Our cost data came in four columns per treatment episode and we're still waiting to get an explanation to help us find out which column to look at and how to analyze that data.

The other retrospective data that we looked at was the OSHA data, and for any site that hasn't reviewed its OSHA data yet, you have something to look forward to. Our goal is to link that data with treatment utilization data, to see if substance abusers are over-represented in the OSHA records.

One thing we talked about was the possibility of coding across sites for occupational title. So we used the Dictionary of Occupational Titles and their breakdowns. If other people are interested in using that too, then it will be interesting to compare across sites.

Ted Miller had an idea for coding injury type as well, and he is going to provide that for us. Dr. Matano will now speak about process issues that are related to our retrospective data.

Dr. Matano:

The overarching theme of our experiences has been the sensitivity of this topic wherever we've discussed it. As we talk about this in regard to all aspects of the work site, the fear related to disclosing data has been very, very intense. This applies to the health management administrator on down the line to the health center, and so on.

People do not feel comfortable releasing this type of data to others. So we're going to be talking about this tomorrow - how to handle the issue of confidentiality. But there has been an intense fear about it, at least at the work site we are studying.

The second thing is that there could be a blending of outcome variables, based on the assumption that what is good for the company is good for the employee. In other words, health outcomes that are positive for the employee will ultimately benefit the employer. That could very well be true, but as times get rough, and recessions hit, the link becomes weaker and the commitment to employee health may waiver. So I think we have in our study a kind of dual purpose, a dual set of outcomes that we should be thinking about - one for the employer, and one for the employee (good health.) We have to study this very carefully.

Third, the archival data, as far as we can see, is going to strengthen this study. However, it has important limitations. For example, our payroll data and our time sheet data are both available in files, and they were intended to have the same employees. It took about a week just to harmonize those two sets of seemingly identical data. There were about 100 employees on one list who were not on the other. Meshing data is very difficult with respect to archival data.

The Workers' Compensation data, the medical records data, and other disciplinary data are biased by the sensitivity of those supervisors, those positions, those people who are fearful of putting anything but alcohol in the record. We were looking at the OSHA data, and there were no deaths attributable to alcohol. There were several reasons for that. Archival data itself can be profoundly biased. So I think we have some strengths in the archival data, but we also have some important limitations.

Someone asked a question, "Why do we have to justify good treatment for this particular disease?" I think that's a really good question. The potential for impacting this particular treatment field is, I think, present in this room, so I'm really encouraged by it.